

Yosemite Community College District

ACTIVE Plan Election Form - 2023-2024

REV 10/01/23

Effective October 1, 2023 thru September 30, 2024, EMPLOYEES may choose between one (1) Kaiser HMO and four (4) Blue Shield (BS) PPO medical plans. Your choices are listed below. <u>Please review the information packet provided for each plan for details, limitations, and exclusions to help you choose the benefits that best meet the needs of you and/or your family. Select your choice by initialing under the plan you wish to enroll.</u>

If you are not making any changes, you do not need to return this form.

MEDICAL PLAN OPTIONS - ACTION REQUIRED

SELECT A PLAN FROM FIVE CHOICES BELOW AND INITIAL YOUR CHOICE:

	District Paid Plan	District Paid Plan	
	Kaiser HMO	Blue Shield PPO 80%-G Plan	NOTELL
Medical Plan:	606394-0058/ACN, ALN, AMN	SISC BSC - SC P021000/01/02	NOTE!!!
Calendar Year Individual/Family Deductible(s):	Not Applicable	\$500 / \$1,000	If changing from Kaiser to
Calendar Year Co-Insurance Maximum:	Med/RX: \$1,500/\$3,000 \$30 Co-Pay	Med \$2,000/\$4,000; Rx \$2,500/\$3,500 \$30 Co-Pay	Blue Shield, or from Blue Shield to
Office Visit Co-Pay & BS Behavioral Health Co-Pay Treatment Co-Insurance after Deductible is met:	Not Applicable	20% after Deductible	Kaiser, you must also complete the appropriate enrollment form.
Prescription - Retail	\$10 Generic / \$30 Brand	\$10 Generic / \$35 Brand	the appropriate emoninent form.
Prescription Drug/Calendar Year/Brand Name		\$200 Single / \$500 Family	
Deductible - Not Applicable to Generic Drugs	Not Applicable	(January 1 thru December 31)	
TOTAL PREMIUM:	\$1,824.00	\$1,904.00	
YCCD-Paid Monthly Premium:	\$1,824.00	\$1,904.00	
Employee Monthly Premium:	\$0.00	\$0.00	
	I Select Kaiser HMO Plan:	I Select BS 80%-G Plan:	
	Buy-Up - 80/20%	Buy-Up - 90/10%	Buy-Up - 100%
THESE PLANS REQUIRE A "POP" FORM	Blue Shield PPO 80%-C	Blue Shield PPO 90%-G	Blue Shield PPO 100%-D
Medical Plan:	SISC BSC - SC P031000/01/02	SISC BSC - SC P041000/01/02	SISC BSC - SC P011000/01/02
Calendar Year Individual/Family Deductible(s):	\$200 / \$500	\$500 / \$1,000	\$300 / \$600
Calendar Year Co-Insurance Maximum:	Med \$1,000/\$3,000, Rx \$2,500/\$3,500	Med \$1,000/\$3,000, Rx \$2,500/\$3,500	Med \$1,000/\$3,000, Rx \$2,500/\$3,500
Office Visit Co-Pay & BS Behavioral Health Co-Pay:	\$20 Co-Pay	\$20 Co-Pay	\$30 Co-Pay
Treatment Co-Insurance after Deductible is met:	20% after Deductible	10% after Deductible	No Charge after Deductible
Prescription - Retail	\$10 Generic / \$35 Brand	\$9 Generic / \$35 Brand	\$10 Generic / \$35 Brand
Prescription Drug/Calendar Year/Brand Name	\$200 Single / \$500 Family	Not Applicable	\$200 Single / \$500 Family
Deductible - Not Applicable to Generic Drugs	(January 1 thru December 31)		(January 1 thru December 31)
TOTAL PREMIUM:	\$2,115.00	\$2,153.00	\$2,280.00
YCCD-Paid Monthly Premium:	\$1,904.00	\$1,904.00	\$1,904.00
Employee Monthly Premium:	\$211.00	\$249.00	\$376.00
	I Select BS 80%-C Buy-Up Plan:	I Select BS 90%-G Buy-Up Plan:	I Select BS 100%-D Buy-Up Plan:
	DENTAL PLAN OPTIONS		
DELTA PREMIER INCENTIVE PLAN - Includes Ortho Coverage begins at 70% and increases to 1009	•	I Select Delta Premier Incentive Plan:	
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